General

Title

Stable coronary artery disease: percentage of patients with stable coronary artery disease who are prescribed aspirin and anti-atherosclerotic medications.

Source(s)

Goblirsch G, Bershow S, Cummings K, Hayes R, Kokoszka M, Lu Y, Sanders D, Zarling K. Stable coronary artery disease. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2013 May. 71 p. [98 references]

Measure Domain

Primary Measure Domain

Clinical Quality Measures: Process

Secondary Measure Domain

Does not apply to this measure

Brief Abstract

Description

This measure is used to assess the percentage of patients age 18 years and older with stable coronary artery disease who are prescribed aspirin and anti-atherosclerotic medications.

Rationale

The priority aim addressed by this measure is to increase the percentage of patients age 18 years and older with a diagnosis of stable coronary artery disease who are prescribed aspirin and anti-atherosclerotic medications.

Antiplatelet Therapy. Aspirin dose in the range of 75 to 150 mg should be given for the long-term prevention of serious vascular events in high-risk patients, and there may be a reduced benefit when increasing the dose over 150 mg daily. Doses available to most clinicians are in increments of 81 mg; therefore, the recommended dose is 81 mg daily.

Patients for whom aspirin is contraindicated (or insufficient) should be treated with clopidogrel 75 mg daily indefinitely.

Statins. Benefit has been demonstrated in all stable coronary artery disease patients treated with statins, regardless of pretreatment cholesterol levels. This was well demonstrated in the MRC/BHF Heart Protection Study. Simvastatin was shown to reduce major cardiovascular events, including death, non-fatal myocardial infarction, and stroke by 15% to 20% in the subgroup of patients with pretreatment levels of less than 100 mg/dL. A similar reduction in events was also observed in patients without documented coronary artery disease, but with peripheral vascular disease, diabetes or hypertension.

Every effort should be made to ensure all patients with coronary artery disease receive optimal lipid therapy. Statin medications are strongly supported as first-line medications due to compelling evidence of mortality reduction from multiple clinical trials.

As-needed Nitrates. In patients with mild stable coronary artery disease, drug therapy may be limited to short-acting sublingual nitrates on an as-needed basis. Use of lower dose (e.g., 0.3 mg or one-half of a 0.4 mg tablet) may reduce the incidence of side effects such as headache or hypotension in susceptible patients.

Beta-blocking Agents. Beta-blockers should be used in all status post-myocardial infarction patients, based on studies showing mortality reduction. They are also the preferred first-line therapy for reducing symptoms of angina in patients with stable coronary artery disease.

Ranolazine. Ranolazine is a stand-alone late sodium channel blocker; it relieves stable angina symptoms and increases exercise tolerance. It demonstrates antianginal and anti-ischemic effects without changing hemodynamic parameters (heart rate or blood pressure). Consider the use of ranolazine when beta-blockers, calcium channel blockers and nitrates are not adequately effective or are not tolerated.

Evidence for Rationale

Antiplatelet Trialists' Collaboration. Collaborative overview of randomised trials of antiplatelet therapy - I: Preparation of death, myocardial infarction, and stroke by prolonged antiplatelet therapy in various categories of patients. BMJ. 1994;38:81-106.

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Goblirsch G, Bershow S, Cummings K, Hayes R, Kokoszka M, Lu Y, Sanders D, Zarling K. Stable coronary artery disease. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2013 May. 71 p. [98 references]

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Shub C. Stable angina pectoris: 1. Clinical patterns. Mayo Clin Proc. 1990 Feb;65(2):233-42. [46 references] PubMed

Primary Health Components

Stable coronary artery disease; aspirin

Denominator Description

Number of stable coronary artery disease patients (see the related "Denominator Inclusions/Exclusions" field)

Numerator Description

Number of stable coronary artery disease patients who are prescribed aspirin and anti-atherosclerotic medications (see the related "Numerator Inclusions/Exclusions" field)

Evidence Supporting the Measure

Type of Evidence Supporting the Criterion of Quality for the Measure

A clinical practice guideline or other peer-reviewed synthesis of the clinical research evidence

Additional Information Supporting Need for the Measure

Unspecified

Extent of Measure Testing

Unspecified

National Guideline Clearinghouse Link

Stable coronary artery disease.

State of Use of the Measure

State of Use

Current routine use

Current Use

not defined yet

Application of the Measure in its Current Use

Measurement Setting

Ambulatory/Office-based Care

Professionals Involved in Delivery of Health Services

not defined yet

Least Aggregated Level of Services Delivery Addressed

Clinical Practice or Public Health Sites

Statement of Acceptable Minimum Sample Size

Unspecified

Target Population Age

Age greater than or equal to 18 years

Target Population Gender

Either male or female

National Strategy for Quality Improvement in Health Care

National Quality Strategy Aim

Better Care

National Quality Strategy Priority

Prevention and Treatment of Leading Causes of Mortality

Institute of Medicine (IOM) National Health Care Quality Report Categories

IOM Care Need

Living with Illness

IOM Domain

Effectiveness

Data Collection for the Measure

Case Finding Period

The time frame pertaining to data collection is monthly.

Denominator Sampling Frame

Patients associated with provider

Denominator (Index) Event or Characteristic

Clinical Condition

Patient/Individual (Consumer) Characteristic

Denominator Time Window

not defined yet

Denominator Inclusions/Exclusions

Inclusions
Number of stable coronary artery disease patients

Population Definition: All patients age 18 and older with stable coronary artery disease diagnosis.

Exclusions
Patients with documented contraindications to aspirin should be excluded from the denominator of this measure.

Exclusions/Exceptions

not defined yet

Numerator Inclusions/Exclusions

Inclusions
Number of stable coronary artery disease patients who are prescribed aspirin and anti-atherosclerotic medications

Exclusions
Contraindications to aspirin use are not defined in the guideline*, but left to the provider's discretion. Some commonly found contraindications are allergy to the drug and history of bleeding ulcer or gastric hemorrhage. When contraindications are present, they need to be noted in the patient's record.

*Refer to the National Guideline Clearinghouse (NGC) summary of the Institute for Clinical Systems Improvement (ICSI) Stable Coronary Artery Disease guideline.

Numerator Search Strategy

Fixed time period or point in time

Data Source

Paper medical record

Type of Health State

Does not apply to this measure

Instruments Used and/or Associated with the Measure

Unspecified

Computation of the Measure

Measure Specifies Disaggregation

Does not apply to this measure

Scoring

Rate/Proportion

Interpretation of Score

Desired value is a higher score

Allowance for Patient or Population Factors

not defined yet

Standard of Comparison

not defined yet

Identifying Information

Original Title

Percentage of patients with stable coronary artery disease who are prescribed aspirin and anti-atherosclerotic medications.

Measure Collection Name

Stable Coronary Artery Disease

Submitter

Institute for Clinical Systems Improvement - Nonprofit Organization

Developer

Institute for Clinical Systems Improvement - Nonprofit Organization

Funding Source(s)

The Institute for Clinical Systems Improvement's (ICSI's) work is funded by the annual dues of the member medical groups and five sponsoring health plans in Minnesota and Wisconsin.

Composition of the Group that Developed the Measure

Work Group Members: Greg Goblirsch, MD (*Work Group Leader*) (River Falls Clinic) (Family Medicine); Spencer Bershow, MD (Fairview Health Services) (Family Medicine); Yun Lu, PharmD, MS (Hennepin County Medical Center) (Pharmacy); Kathy Zarling, RN, MS, CNS (Mayo Clinic) (Nursing); Marek Kokoszka, MD (Park Nicollet Health Services) (Cardiology); Debra M. Sanders, RD (River Falls Medical Clinic) (Dietetics); Kathy Cummings, RN, BSN, MA (Institute for Clinical Systems Improvement [ICSI]) (Project Manager); Rochelle Hayes, BS (ICSI) (Systems Improvement Coordinator)

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The Institute for Clinical Systems Improvement (ICSI) has long had a policy of transparency in declaring potential conflicting and competing interests of all individuals who participate in the development, revision and approval of ICSI guidelines and protocols.

In 2010, the ICSI Conflict of Interest Review Committee was established by the Board of Directors to review all disclosures and make recommendations to the board when steps should be taken to mitigate potential conflicts of interest, including recommendations regarding removal of work group members. This committee has adopted the Institute of Medicine Conflict of Interest standards as outlined in the report Clinical Practice Guidelines We Can Trust (2011).

Where there are work group members with identified potential conflicts, these are disclosed and discussed at the initial work group meeting. These members are expected to recuse themselves from related discussions or authorship of related recommendations, as directed by the Conflict of Interest committee or requested by the work group.

The complete ICSI policy regarding Conflicts of Interest is available at the ICSI Web site .

Disclosure of Potential Conflicts of Interest

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National, Regional, Local Committee Affiliations: None
Guideline Related Activities: None
Research Grants: None
Financial/Non-Financial Conflicts of Interest: None

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Guideline Related Activities: None
Research Grants: None
Financial/Non-Financial Conflicts of Interest: None

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Guideline Related Activities: None
Research Grants: None
Financial/Non-Financial Conflicts of Interest: None

Adaptation

This measure was not adapted from another source.

Date of Most Current Version in NQMC

2013 May

Measure Maintenance

Scientific documents are revised every 12 to 24 months as indicated by changes in clinical practice and literature.

Date of Next Anticipated Revision

The next scheduled revision will occur within 24 months.

Measure Status

This is the current release of the measure.

This measure updates a previous version: Institute for Clinical Systems Improvement (ICSI). Stable coronary artery disease. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2011 Apr. 58 p.

The measure developer reaffirmed the currency of this measure in January 2016.

Measure Availability

Source available for purchase from the Institute for Clinical Systems Improvement (ICSI) Web site. Also available to ICSI members for free at the ICSI Web site and to Minnesota health care organizations free by request at the ICSI Web site.

For more information, contact ICSI at 8009 34th Avenue South, Suite 1200, Bloomington, MN 55425; Phone: 952-814-7060; Fax: 952-858-9675; Web site: www.icsi.org; E-mail: icsi.info@icsi.org.

NQMC Status

This NQMC summary was completed by ECRI on July 14, 2004.

This NQMC summary was updated by ECRI Institute on June 9, 2005, June 29, 2006, June 4, 2007, November 18, 2009, October 29, 2012, and again on January 20, 2014.

The information was reaffirmed by the measure developer on January 13, 2016.

Copyright Statement

Production

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